CHAPTER III: INTERMEDIARY BILLING

CHAPTER III – FISCAL INTERMEDIARY BILLING

OBJECTIVE

This chapter provides participants with an overview of the changes to Intermediary billing under the ambulance fee schedule.

NEW CODING REQUIREMENTS

The implementation of the ambulance fee schedule has generated new coding requirements for intermediary claims. The following are the concepts from the ambulance fee schedule that require changes in coding claims:

Medicare recognizes seven categories of ground ambulance

1. **Basic Life Support (BLS)**
2. **Basic Life Support, Emergency (BLS-E)**
3. **Advanced Life Support, Level 1 (ALS1)**
4. **ALS1, Emergency (ALS1-E)**
5. **ALS, Level 2 (ALS2)**
6. **Specialty Care Transport (SCT)**
7. **Paramedic Intercept (PI)**

1. Seven categories of ground ambulance services;
2. Two categories of air ambulance services;
3. Payment under the fee schedule is based on the condition of the beneficiary, not on the type of vehicle used. However, during the transition period the reasonable cost portion of the blended payment is based on the vehicle used under the following circumstances: (1) ALS Vehicle Used, Emergency Transport, No ALS Service Furnished, and (2) ALS Vehicle Used, Non-Emergency Transport, No ALS Service Furnished; and (3) an emergency response.
4. Payment is determined by the point of pickup (as reported by the five-digit zip code);
5. Increased payment for additional rural ground miles ;
6. New HCPCS codes are effective for dates of service beginning January 1, 2001. The exception to this are HCPCS codes Q3019 and Q3020 which are effective April 1, 2002.;
7. No grace period for old HCPCS codes for dates of service after January 1, 2001 except HCPCS codes A0380 and A0390. Beginning April 1, 2002, all ground mileage should be reported using HCPCS code A0425. HCPCS codes A0380 and A0390 will be invalid beginning April 1, 2002.

ADDITIONAL CHANGES ASSOCIATED WITH THE FEE SCHEDULE

ITEMS AND SERVICES

Payment under the fee schedule for ambulance services is composed of a base rate payment plus a separate payment for mileage.

The payment for items and services is included in the fee schedule. These items and services include but are not limited to:

Oxygen
Drugs
Extra attendants
EKG testing

HCPCS CODES

The following codes must be used to reflect the type of service provided not the type of vehicle used. (PM AB-01-185)

HCPCS CODES EFFECTIVE FOR DATES OF SERVICE ON OR AFTER JANUARY 1, 2001

A0425	Ground mileage, per statute mile
A0426	Ambulance service, advanced life support, non-emergency transport, level 1(ALS1)
A0427	Ambulance service, advanced life support, emergency transport, level 1 (ALS1-E)
A0428	Ambulance service, basic life support, non-emergency transport (BLS)
A0429	Ambulance service, basic life support, emergency transport (BLS-E)
A0430	Ambulance service, conventional air services, transport, one way (FW)
A0431	Ambulance service, conventional air service, transport, one way (RW)
A0432	Paramedic Intercept, rural area, transport furnished by a volunteer ambulance company which is prohibited by state law from billing third party payers (PI)
A0433	Advanced life support, level 2 (ALS2)
A0434	Specialty Care Transport (SCT)
A0435	Fixed wing air mileage, per statue mile
A0436	Rotary wing air mileage, per statue mile

HCPCS CODES FOR SERVICES RENDERED PRIOR TO JANUARY 1, 2001

A0030	Ambulance service; conventional air service, transport
A0040	Ambulance service; air, helicopter service, transport
A0050	Ambulance service, emergency, water, special transportation services
A0320	Ambulance service; basic life support (BLS), non-emergency transport, supplies included, mileage separately billed
A0322	Ambulance Service; basic life support (BLS), emergency transport, supplies included, mileage separately billed
A0324	Ambulance service; advanced life support (ALS), non-emergency transport, no specialized ALS services rendered, supplies included, mileage separately billed
A0326	Ambulance service; advanced life support (ALS), non-emergency transport, specialized ALS services rendered, supplies included, mileage separately billed
A0328	Ambulance service; advanced life support (ALS), emergency transport, no specialized ALS services rendered, supplies included, mileage separately billed
A0330	Ambulance service; advanced life support (ALS), emergency transport, specialized ALS services rendered, supplies included, mileage separately billed
A0380	Basic life support (BLS) mileage, per mile
A0390	Advanced life support (ALS) mileage, per mile

HCPCS codes A0380 and A0390 will be invalid effective April 1, 2002.

Temporary HCPCS Codes for ambulance fee schedule

Q3019	Ambulance service, Advanced Life Support (ALS) vehicle used, emergency transport, no ALS level service furnished

Q3020 Ambulance service, Advanced Life Support (ALS) vehicle used, non-emergency transport, no ALS level service furnished

The following ambulance services do not have a separate level of service for emergency condition.

1. Paramedic Intercept
2. Advanced Life Support, Level 2 (ALS2)
3. Fixed Wing Air Ambulance (FW)
4. Rotary Wing Air Ambulance (RW)

See AB-01-185 for a crosswalk of old codes to new codes.

MEDICARE SUMMARY NOTICE (MSN) AND EXPLANATION OF MEDICARE BENEFITS (EOMB)

Continue using existing MSN and EOMB messages.

CODING GUIDELINES

For services rendered on or after January 1, 2001, use the HCPCS code that best describes the services rendered.

Ambulance claims should be submitted on the Form HCFA-1450 (UB-92) form or its electronic equivalent.

See AB-01-185 for a crosswalk of old codes to new codes.

BILL TYPES

Bill type is a mandatory three-position alphanumeric field providing the following information:

First position identifies type of facility (for example, Hospital, Skilled Nursing Facility or Special Facility)

Second position identifies bill classification (Classifies the Type of Care provided such as Inpatient-Part B only or Outpatient)

Third position identifies the frequency of billing (for example, Admission, Interim Claim, Discharge, Late Charge, Adjustment or Void/Cancel)

Data elements in the HCFA uniform billing specifications are consistent with the Form HCFA-1450. Type of Bill is located in Form Locator (FL) 4 of the 1450 and record type 40, field 4 in the electronic specifications.

Appropriate Ambulance Bill Types:

- 13X Hospital Outpatient
- 22X Skilled Nursing Facility, Inpatient Part B only
- 23X Skilled Nursing Facility, Outpatient
- 32X Home Health, visits under a Plan of Treatment under Part B
- 33X Home Health, visits under a Plan of Treatment under Part A including DME under Part A
- 34X Home Health, Medical and Surgical services not under a Plan of Treatment
- 83X Specialty Facility, Ambulatory Surgery Center performed in a non-OPPS setting such as Indian Health Service Hospitals, Maryland hospitals under PPS waiver, and Hospitals located in Saipan, American Samoa and Guam)

  NOTE: Claims submitted with bill type 13X will no longer be changed to 831 by the claims processing system.
- 85X Critical Access Hospitals (CAHs)

VALUE CODE A0 (ZERO)

The value code is defined as "ZIP Code of the location from which the beneficiary is initially placed on board the ambulance."

Value Code A0 (Zero) must equal the "ZIP Code of the location from which the beneficiary is initially placed on board the ambulance."

It is required on all ambulance claims.

Coding A0 (Zero)

Value code A0 should be reported in Form Locator (FLs) 39-41 "Value Codes."

Providers report the 5-digit zip code in the dollar portion of the form locator, right justified to the left of the dollar/cents delimiter.

Providers utilizing the UB-92 flat file report the 5-digit zip code in Record Type 41, field(s) 16 - 39.

X12 institutional claims transactions, show "HI*BE:A0:::12345~, 2300 Loop, HI segment" where 12345 is replaced by the zip code of the origin.

MULTIPLE PATIENTS

When multiple patients are transported at the same time, providers must prepare a separate claim for each patient.

Payment will be prorated based on the number of patients transported; ambulance fee schedule allowance and level of medically appropriate service(s) furnished.

Until further notice, current billing practices by contractor should be followed. (Reference: ambulance fee schedule, Final Questions and Answers dated November 15, 2000, question/answer number 24 contained in the appendix.)

Providers must prepare a separate claim for a beneficiary for each trip if the points of pickup are located in different ZIP Codes.

MULTIPLE AMBULANCE TRIPS

Only one zip code may be reported per claim; because billing requirements do not allow value codes (zip codes) to be line item specific.

More than one ambulance trip may be reported on the same claim only if all points of pickup have the same zip code.

Providers must prepare a separate claim for a beneficiary for each trip if the points of pickup are located in different zip codes.

REVENUE CODE REPORTING

Each loaded one-way ambulance trip must be reported with a unique pair of revenue code lines on a claim.

Ambulance services should be billed utilizing revenue code 540 in FL 42 "Revenue Code" or Providers utilizing the UB-92 flat file report the revenue code in Record Type 61, field 5.

Report revenue code 540 (ambulance) on two separate and consecutive line items to accommodate both the base rate ambulance service and the mileage HCPCS codes for each ambulance trip provided during the billing period.

HCPCS REPORTING

Report one HCPCS code per revenue code line.

New HCPCS codes established for the ambulance fee schedule must be reported.

No other HCPCS are acceptable for the reporting of base rate ambulance trip and mileage.

New HCPCS codes reflect the category of service provided and then only when the service is medically necessary.

For transition purposes and reference see AB-01-185 for a crosswalk to the new codes Not all previous HCPCS codes are applicable to providers since providers have been reporting the base rate and mileage HCPCS codes (Method 2).

HCPCS code(s) must reflect category of service provided and then only when the service is medically necessary.

One of the following HCPCS codes must be reported in FL 44 "HCPCS/Rates" or Providers utilizing the UB-92 flat file report the HCPCS code in Record Type 61, field 6 for each base rate ambulance trip provided during the billing period:

A0426
A0427
A0428 (based on fee schedule implementation)
A0429 (based on fee schedule implementation)
A0430
A0431
A0432
A0433
A0434

In addition, one of the following mileage HCPCS codes must be reported:

A0425 (based on fee schedule implementation)
A0435
A0436

On April 1, 2002, the new HCPCS codes must be used to reflect the type of service the beneficiary received and not the type of vehicle used except during the transition period for the following circumstances: ALS Vehicle Used, Emergency Transport, No ALS Service Furnished, and ALS Vehicle Used, Non-Emergency Transport, No ALS Service Furnished;

ALS Vehicle Used, Emergency Transport, No ALS Service Furnished

During the transition period, if an ALS vehicle is used for an emergency transport, but no ALS level service is furnished, providers must report Q3019.

ALS Vehicle Used, Non-Emergency Transport, No ALS Service Furnished

During the transition period, if an ALS vehicle is used for a non-emergency transport, but no ALS level service is furnished, providers must report Q3020.

A POSSIBLE DELAY IN CODING CHANGES

With the fee schedule delayed beyond January 1, 2001, the following requirements will be changed:

1. Medicare will continue to pay for an ALS vehicle used, but no ALS service furnished. Before January 1, 2002, providers using an ALS vehicle to furnish a BLS service billed HCPCS codes A0324 or A0328. They may continue to bill for these services but should bill the new HCPCS codes, A0426 (ALS1) or A0427 (ALS 1 emergency) as appropriate until April 1, 2002. With services furnished on or after April 1, 2002, these services should be billed as Q3019 or Q3020, as described above.

2. Until April 1, 2002, providers should continue to bill BLS mileage as A0380 and ALS mileage as A0390. With services furnished on or after April 1, 2002,all ground mileage must be billed as A0425.

INSTANCES WHERE THE PROVIDER DOES NOT INCUR ANY COST FOR MILEAGE

The following are instances where the provider does not incur any cost for mileage:

- Subsidy is received from a local municipality or the transport vehicle is owned and operated by a governmental or volunteer entity.

- Beneficiary is pronounced dead *after the ambulance is called but before the ambulance arrives at the scene.*

Two revenue code line items are required. Base rate ambulance trip and mileage should be reported as separate revenue code line items.

Report appropriate HCPCS code(s) and modifiers per revenue code line item.

Until further notice, providers should report:

Non-Covered Charges

If no cost for mileage is incurred (based on billing exceptions) report $1.00 in the Non-Covered Charges (FL48) or UB-92 flat file, record 61.

One unit in FL46 “Service Units” or providers utilizing the UB-92 flat file, report one service unit in Record Type 61, field 9.

$1.00 in FL47 “Total Charges” or providers utilizing the UB-92 flat file report $1.00 in, Record Type 61, field 11.

$1.00 in FL48 "Non-covered Charges” or Providers utilizing the UB-92 flat file report $1.00 in non-covered charges in Record Type 61, field 12.

EFFECT OF BENEFICIARY’S DEATH

Beneficiary pronounced dead *after being loaded on the ambulance (regardless of whether the pronouncement is made during or subsequent to the transport) and represents a “dead on arrival” DOA scenario.*

Two revenue line items are required. Base rate ambulance trip and *actual* mileage should be reported as separate revenue code line items.

Report appropriate HCPCS code(s), modifiers, service unit(s), and total charge(s) per revenue code line item.

Beneficiary pronounced dead *prior to the time the ambulance is called.*

No payment will be made.

Beneficiary pronounced dead *after the time the ambulance is called, but before the ambulance arrives on the scene.*

Payment is made in the amount of a BLS base rate for ground or the appropriate urban base rate for air ambulance. No payment is made for mileage.

BILLING EXCEPTIONS

Patient refused ambulance transport.

Ambulance arrives, assessment is completed, no medical necessity identified for ambulance transport.

Since no ambulance transport was provided, no ambulance claim should be submitted.

No payment will be made.

MODIFIER REPORTING

An origin/destination HCPCS modifier and the QM or QN modifier must be present for each base rate ambulance trip and mileage revenue code line item.

Modifier(s) must be reported in FL 44 "HCPCS/Rates." Providers utilizing the UB-92 flat file report the HCPCS code in Record Type 61, field(s) 7-8 for each base rate ambulance trip and mileage revenue code line item provided during the billing period.

Modifier Reporting

An origin/destination HCPCS modifier and the QM or QN modifier must be present for each ambulance trip.

Modifiers are used with HCPCS code to:

1. Report an origin and destination modifier for each ambulance trip;

2. Either a QM or QN modifier to describe whether the service was provided under arrangement or directly.

Origin and Destination Modifiers

The following values **must be used** in combinations of two in order to form a two-position modifier. The modifier must indicate both origin and destination. For example, if the origin is the patient's home, and the destination is a hospital, the modifier would be RH; if the origin is a hospital, and the destination is a nursing home, the modifier would be HE, etc.

The first position alphabetic value is used to report the origin of service.

The second position alphabetic value is used for the destination of service.

Modifiers must indicate both the origin and destination for each ambulance trip provided.

The first alphabetic position value equals origin of service.

The second alphabetic position value equals destination of service.

The origin/destination codes are defined below:

D	Diagnostic or therapeutic site other than P or H
E	Residential, domiciliary, custodial facility (nursing home, not skilled nursing facility)
G	Hospital-based dialysis facility (hospital or hospital-related)
H	Hospital
I	Site of transfer (for example, airport or helicopter pad) between modes of ambulance transport
J	Non-hospital-based dialysis facility
N	Skilled nursing facility (SNF)
P	Physician's office (includes HMO non-hospital facility, clinic, etc.)
R	Residence
S	Scene of accident or acute event
X	Intermediate stop at physician's office enroute to the hospital (includes HMO non-hospital facility, clinic, etc.)

NOTE: Modifier X can only be used as a destination code in the second position of a modifier. Therefore, it should only be reported in the second position of the modifier.

QL Patient pronounced dead after an ambulance called

For claims with dates of service on or after July 1, 2002, when a beneficiary is pronounced dead after an ambulance (ground or air) is called, but before the ambulance arrives, providers must report QL (Patient dead after ambulance called) instead of the origin and destination modifier. In addition to the QL modifier, provider must continue to report one of the following modifiers with every HCPCS code to describe whether the service was provided under arrangement or directly:

QM/QN MODIFIER

One of the following modifiers must be reported for each ambulance trip to describe whether the service was provided under arrangement or directly:

QM: Ambulance service provided under arrangement by a provider of services; or
QN: Ambulance service furnished directly by a provider of services.

LINE ITEM DATES OF SERVICE REPORTING

Line item dates of service per revenue code line are required and must be reported in FL 45 "Service Date." Providers utilizing the UB-92 flat file report the service date in Record Type 61, field 13.

Report two separate revenue code lines for every ambulance trip provided along with the date of service of each trip (PM A-01-48).

SERVICE UNITS REPORTING

For line items reflecting HCPCS codes A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, or A0434**,** providers are required to report service units for each ambulance trip provided in FL 46 "Service Units" or providers utilizing the UB-92 flat file, report service units in Record Type 61, field 9.

Service units for each occurrence of these HCPCS codes are always equal to one.

For line items reflecting HCPCS code A0425, A0435, or A0436, report the number of loaded miles.

Unloaded trips and mileage are NOT reported. Code one mile for trips less than a mile. Miles must be whole numbers. If a trip has a fraction of a mile, round up to the nearest whole number.

TOTAL CHARGES REPORTING

When line items reflect HCPCS codes A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, or A0434, (ambulance trip/ambulance service{s}) providers are required to report in FL 47 "Total Charges." Providers utilizing the UB-92 flat file report total charges in Record Type 61, field 11. Providers report the actual charge for the ambulance service including all supplies used for the ambulance trip, but excluding the charge for mileage.

Line items reflecting HCPCS codes (miles) A0425, A0435, or A0436, report the actual charge for mileage.

Total Charges Reporting

HCPCS codes A0426 through A0434 report the actual charge including all supplies used but excluding mileage charges.

HCPCS codes A0425, A0435 or A0436 report the actual charge for mileage.